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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Part 412**

**[CMS-1709-N]**

**RIN 0938-ZB49**

# Medicare Program; Certain Changes to the Low-Volume Hospital Payment Adjustment Under the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals for Fiscal Years 2011 through 2017

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Application of a payment adjustment.

**SUMMARY:** This document announces changes to the payment adjustment for low-volume hospitals under the hospital inpatient prospective payment systems (IPPS) for acute care hospitals for fiscal years (FYs) 2011 through 2017 in accordance with section 429 of the Consolidated Appropriations Act, 2018.

**DATES:** Effective date: August 22, 2018.

Applicability date: The provisions described in this document are applicable for discharges on or after October 1, 2010, and on or before September 30, 2017, in accordance with section 429 of the Consolidated Appropriations Act, 2018.

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**SUPPLEMENTARY INFORMATION:**

## I. Background

On March 23, 2018 the Consolidated Appropriations Act, 2018 (Pub. L. 115–141) was enacted. Section 429 of the Consolidated Appropriations Act, 2018 makes certain changes to the payment adjustment for low-volume hospitals for fiscal years (FYs) 2011 through 2017 relating to the application of the mileage criterion for Indian Health Service and non-Indian Health Service facilities.

## II. Provisions of the Document

### A. Changes to the Payment Adjustment for Low-Volume Hospitals in FYs 2011 through 2017

1. Background

Section 1886(d)(12) of the Act provides for an additional payment to each qualifying low-volume hospital under the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals beginning in FY 2005. CMS implemented this provision in the regulations at 42 CFR 412.101. The payment adjustment to a low-volume hospital provided for under section 1886(d)(12) of the Act is "[i]n addition to any payment calculated under this section." Therefore, meaning the payment adjustment is based on the per discharge amount paid to the qualifying hospital under section 1886 of the Act. In other words, the low-volume hospital payment adjustment is based on total per discharge payments made under section 1886 of the Act, including capital, disproportionate share hospital (DSH), indirect medical education (IME), and outlier payments. For sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs), the low-volume hospital payment adjustment is based in part on either the

Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

The Affordable Care Act amended section 1886(d)(12) of the Act by modifying the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals, effective only for discharges occurring during FYs 2011 and 2012, and subsequent legislation extended those temporary modifications through FY 2018. (The most recent statutory extension of those temporary changes to the low-volume hospital payment policy was for FY 2018 and is discussed in a document (CMS 1677-N) that appeared in the April 26, 2018 **Federal Register** (83 FR 18301).) Specifically, those provisions amended the qualifying criteria for low volume hospitals under section 1886(d)(12)(C)(i) of the Act to specify that, for FYs 2011 through 2018, a subsection (d) hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year. In addition, these provisions amended section 1886(d)(12)(D) of the Act to provide that for FYs 2011 through 2018, the low-volume hospital payment adjustment (that is, the percentage increase) is to be determined using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under Part A in the fiscal year to zero percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year. (We note that under § 412.101(b)(2)(ii), for FYs 2011 through 2017, a hospital's Medicare discharges from the most recently available MedPAR data, as determined by CMS, are used to determine whether the hospital meets the discharge criterion to receive the low

volume hospital payment adjustment in the applicable fiscal year. In the FY 2019 IPPS/LTCH PPS final rule, we finalized conforming changes to this provision to reflect that the low-volume hospital payment adjustment policy in effect for FY 2018 is the same low-volume hospital payment adjustment policy in effect for FYs 2011 through 2017 (83 FR 41144, August 17, 2018).

2. Treatment of Indian Health Service and Non-Indian Health Service Facilities

Section 1886(d)(12)(C) of the Act requires that, in order to qualify for the low volume hospital payment adjustment, a hospital must be located more than a specified number of miles from the nearest subsection (d) hospital (referred to as the mileage criterion, which is implemented at § 412.101(b)(2)). Since CMS considers Indian Health Service (IHS) and Tribal hospitals (collectively referred to here as "IHS hospitals") to be subsection (d) hospitals, for the reasons discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38188 through 38189), we adopted a parallel adjustment at § 412.101(e) which specifies that, for discharges occurring in FY 2018 and subsequent years, only the distance between IHS hospitals would be considered when assessing whether an IHS hospital meets the mileage criterion under § 412.101(b)(2), and similarly, only the distance between non-IHS hospitals would be considered when assessing whether a non-IHS hospital meets the mileage criterion under § 412.101(b)(2).

While the policy finalized in the FY 2018 IPPS/LTCH PPS final rule addresses FY 2018 and subsequent fiscal years, section 429 of the Consolidated Appropriations Act, 2018 amended section 1886(d)(12)(C) of the Act by adding a new clause (iii) specifying that for purposes of determining whether an IHS or a non-IHS hospital meets the mileage criterion under section 1886(d)(12)(C)(i) of the Act with respect to FY 2011

or a succeeding year, the Secretary shall apply the policy described in the regulations at § 412.101(e) (as in effect on the date of enactment). In other words, under this statutory change, the special treatment with respect to the proximities between IHS and non-IHS hospitals as set forth in § 412.101(e) for discharges occurring in FY 2018 and subsequent fiscal years is now also applicable for purposes of applying the mileage criterion for the low-volume hospital payment adjustment for FYs 2011 through 2017. Therefore, when assessing the mileage criterion under § 412.101(b)(2) for FYs 2011 through 2017, an IHS hospital would be considered to have met the mileage criterion in the applicable year if it was more than 15 road miles from the nearest IHS hospital, and a non-IHS hospital would be considered to have met the mileage criterion in the applicable year if it was more than 15 road miles from the nearest non-IHS hospital.

B. Implementation of the Low-Volume Hospital Payment Adjustment under Section 429 of the Consolidated Appropriations Act, 2018

Section 429 of the Consolidated Appropriations Act, 2018 applies the policy at § 412.101(e) to prior years, that is, for discharges occurring during FYs 2011 through 2017. To implement these changes, hospitals that qualify for the low-volume hospital payment adjustment under the provisions of the Consolidated Appropriations Act, 2018 may receive the low-volume hospital payment adjustment as part of the cost report settlement and reopening process for each cost report that includes discharges from one of the applicable fiscal years (that is, from FYs 2011 through 2017). In the event a hospital, having followed our process to request the low-volume hospital payment adjustment as described in this document, qualifies as a low-volume hospital for discharges occurring in one of the applicable fiscal years and those discharges are in a

cost report that has been settled, the Medicare Administrative Contractors (MAC) will reopen such cost reports in accordance with 42 CFR 405.1885 which allows for the reopening of cost reports upon request only if a request to reopen is received by the MAC within 3 years of the date of the determination or decision that is the subject of the reopening or if the cost report is the subject of a pending jurisdictionally proper appeal before the Provider Reimbursement Review Board or CMS Administrator. Therefore, the application of the low-volume hospital payment adjustment under the provisions of section 429 of the Consolidated Appropriations Act, 2018 will only be applied to discharges occurring in FYs 2011 through 2017 (as applicable) that are in cost reports that are either currently open or for which the hospital requests reopening within the 3-year reopening period by making a request to the MAC with the information described in this document. In this document, we are explicitly directing the MACs to reopen and revise these matters, but only under the circumstances and for the cost reporting periods specified herein and subject to the time limits specified both in 42 CFR 405.1885(b) and this document. (See 42 CFR 405.1885(c)(1).) If a hospital's reopening request is untimely or if a hospital fails to provide adequate written documentation as described in this document, the MAC may deny the reopening request.

We are directing a reopening here under the circumstances described solely in response to the amendment made by section 429 of the Consolidated Appropriations Act, 2018, which changed the application of the mileage criterion for purposes of the low-volume hospital payment adjustment for FYs 2011 through 2017. We reiterate here that, apart from the specific circumstances, time periods, and cost reporting periods for which we are explicitly directing reopening in this document, reopening denials by the MAC in

this and other contexts are discretionary and unreviewable under *Your Home Visiting Nurse Servs., Inc. v. Shalala,* 525 U.S. 449 (1999) and related precedent.

We note, any reopening under this procedure shall be for the sole purpose of making a low-volume hospital payment adjustment under the provisions of section 429 of the Consolidated Appropriations Act, 2018 and for no other purpose. (For additional information on the reopening regulations at 42 CFR 405.1885, refer to the following final rules published in the **Federal Register**: (67 FR 50096), (73 FR 30230), and (78 FR 75162) as well as sections 2931 through 2932 of chapter 29 of the Provider Reimbursement Manual (PRM), Part 1.)

The changes to the low-volume hospital payment adjustment under section 429 of the Consolidated Appropriations Act, 2018 do not affect the discharge criterion in place between FYs 2011 and 2017. Thus, in accordance with the existing regulations at § 412.101(b)(2)(ii) and consistent with our implementation of the low-volume hospital payment adjustment in FYs 2011 through 2017, the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment in accordance with the changes under section 429 of the Consolidated Appropriations Act, 2018 is the same discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment for discharges that occurred in that fiscal year; that is, the most recent data available at the time of the development of the payment rates and factors established in the corresponding final rule. Under § 412.101(b)(2)(ii), for FYs 2011 through 2017, a hospital's Medicare discharges from the most recently available MedPAR data for the applicable fiscal year, as determined by CMS, are used to determine whether the hospital meets the discharge criterion to receive the low-volume

payment adjustment in the applicable year. The applicable low-volume percentage increase for FYs 2011 through 2017 is determined using a continuous linear sliding scale equation that results in a low-volume adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges (§ 412.101(c)(2)).

For the discharge data source used to identify qualifying low-volume hospitals and to calculate the payment adjustment for FY 2011, refer to the chart in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50242 through 50274) or the 'Medicare Discharge Count for FY 2011 Low Volume Adjustment' file on the "Files for FY 2011 Final Rule and Correction Notice" home page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS1255464.html). For FYs 2012 through 2017, Table 14 of each year's respective IPPS/LTCH PPS final rule (which is available through the Internet on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html under "Acute Inpatient - Files for Download" for the respective year) lists the "subsection (d)" hospitals with fewer than 1,600 Medicare discharges based on the applicable data source and their payment adjustment for that fiscal year (if eligible).

These discharges and corresponding payment adjustment are based on the most recent data available at the time of the development of that year's payment rates and factors established in the corresponding final rule. (For additional details on the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment for FYs 2011 through 2017, refer to the following FY 2011 (75 FR

50241 through 50275); FY 2012 (76 FR 51679 through 51680); FY 2013 (78 FR 14689 through 14691); FY 2014 ((79 FR 15022 through 15025) and (79 FR 34444 through 34446)); FY 2015 ((80 FR 49998 through 49999) and Change Request 9197 (Transmittal 3281; June 5, 2015)); FY 2016 (80 FR 49595 through 49597); and FY 2017 (81 FR 56941 through 56943).) The list of hospitals with fewer than 1,600 Medicare discharges for each of FYs 2011 through 2017 (previously described) does not reflect whether or not the hospital meets the mileage criterion. In addition to meeting the discharge criterion, an IHS hospital would be eligible for the low-volume hospital payment adjustment for an applicable fiscal year under the provisions of section 429 of the Consolidated Appropriations Act, 2018 if, in the applicable fiscal year, it was located more than 15 road miles from the nearest IHS hospital. Likewise, a non-IHS hospital meeting the discharge requirement would be eligible for the low-volume hospital payment adjustment for an applicable fiscal year under the provisions of section 429 of the Consolidated Appropriations Act, 2018 if, in the applicable fiscal year, it was located more than 15 road miles from the nearest non-IHS hospital.

We are using the following procedure for a hospital to request the low-volume hospital payment adjustment for any applicable fiscal years between FYs 2011 and 2017 under the provisions of section 429 of the Consolidated Appropriations Act, 2018. In order for the applicable low-volume hospital payment adjustment to be applied for an applicable fiscal year's discharges in an open or reopenable cost report(s), a hospital must notify and provide documentation to its MAC in writing that it meets the mileage criterion under the provisions of section 429 of the Consolidated Appropriations Act, 2018 in the applicable fiscal year (as described in this document). In the case of a

reopenable cost report, the hospital must request a reopening when submitting its written notification and documentation to its MAC. We note, for a hospital to receive the low-volume payment adjustment in FYs 2011 through 2017 under the provisions of the Consolidated Appropriations Act, 2018, the hospital must have been unable to meet the mileage criterion for that fiscal year prior to the enactment of the Consolidated Appropriations Act, 2018 (that is, the provisions of section 429 of the Consolidated Appropriations Act, 2018 do not affect hospitals which met the mileage criterion without regard to this provision). Specifically, for an IHS hospital to be eligible to receive the low-volume hospital payment adjustment in FYs 2011 through 2017 under section 429 of the Consolidated Appropriations Act, 2018, that IHS hospital must not have been able to meet the mileage criterion in the applicable fiscal year based on its proximity to a non-IHS hospital. Similarly, for an non-IHS hospital to be eligible to receive the low-volume payment adjustment in FYs 2011 through 2017 under section 429 of the Consolidated Appropriations Act, 2018, that non-IHS hospital must not have been able to meet the mileage criterion in the applicable fiscal year based on its proximity to an IHS hospital. We encourage hospitals to notify their MAC as soon as possible because, as previously noted, under 42 CFR 405.1885, reopening a cost report is limited to 3 years after cost report settlement. In other words, the application of the low-volume hospital payment adjustment under the provisions of section 429 of the Consolidated Appropriations Act, 2018 is limited to discharges occurring in FYs 2011 through 2017 (as applicable) that are in cost reports that are either currently open or within the 3-year reopening period. Therefore, to receive the low-volume payment adjustment for discharges in FYs 2011 through 2017, the written request must be received by the MAC prior to the close of the

3-year period for the cost report that includes such discharges.

The use of a Web-based mapping tool as part of documenting that the hospital meets the mileage criterion for low-volume hospitals in the applicable fiscal year is acceptable. The MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles, as defined in the regulations at § 412.101(a)) from the hospital requesting low-volume hospital status, is sufficient to document that the hospital requesting low-volume hospital status meets the mileage criterion in the applicable fiscal year (and had previously been unable to meet the mileage criterion in that fiscal year as described in this document). The MAC may follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume mileage criterion for any applicable fiscal year. In addition, the MAC will refer to the hospital's Medicare discharge data determined by CMS for the applicable fiscal year(s) to determine whether or not the hospital met the discharge criterion in that fiscal year, and the amount of the low-volume hospital payment adjustment for such year(s), once it is determined that the mileage criterion has been met. (The applicable Medicare discharge data for each of FYs 2011 through 2017 is previously described.) In addition, in order to receive the low-volume hospital payment adjustment, sufficient documentation in the written request to the MAC must include the following to demonstrate that the hospital was unable to meet the mileage criterion for that fiscal year prior to the enactment of the Consolidated Appropriations Act, 2018. For each applicable fiscal year, an IHS hospital must provide documentation to its MAC that it was not able to meet the mileage criterion in the applicable fiscal year based on its proximity to a non-IHS hospital. Similarly, a

non-IHS hospital must provide documentation to its MAC that it was not able to meet the mileage criterion in the applicable fiscal year based on its proximity to an IHS hospital.

Program guidance on the implementation of this provision, including instructions for cost report settlement and reopening as applicable, will be announced in an upcoming transmittal. We intend to make any conforming changes to the regulations text at 42 CFR 412.101 to reflect the changes to the low-volume hospital payment adjustment policy in accordance with the amendments made by section 429 of the Consolidated Appropriations Act, 2018 as described in this document in future rulemaking.

## III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

## IV. Regulatory Impact Statement

### A. Statement of Need

This document is necessary to update the low-volume hospital payment adjustment policy for FYs 2011 through 2017 to reflect changes provided by section 429 of the Consolidated Appropriations Act, 2018. Section 429 of the Consolidated Appropriations Act, 2018 makes certain changes to the payment adjustment for low-volume hospitals for FYs 2011 through 2017 relating to the application of the mileage criterion for IHS and non-IHS hospitals.

### B. Overall Impact Statement

We have examined the impacts of this document as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order

13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for regulatory actions with economically significant effects ($100 million or more in any 1 year). Although we do not consider this document to constitute a substantive rule or regulatory action, the

monetary impact of the changes announced in this document is approximately a $40 million increase in low-volume hospital payments total for FYs 2011 through 2017 relative to the estimates included in the respective FY IPPS/LTCH PPS final rules.

C. Anticipated Effects

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. We estimate that most hospitals and most other providers and suppliers are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $7.5 to $34.5 million in any 1 year). (For details on the latest standard for health care providers, we refer readers to page 33 of the Table of Small Business Size Standards for NAIC 622 at the Small Business Administration's Web site at https://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We note that we expect the effects of the changes announced in this document to impact only approximately 15 providers.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for

purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals. As noted previously, we expect the effects of the changes announced in this document to impact only approximately 15 providers.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104-4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately $150 million. The changes announced in this document will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. The changes announced in this document will not have a substantial effect on State and local governments.

Executive Order 13771, entitled "Reducing Regulation and Controlling Regulatory Costs," was issued on January 30, 2017, and requires that the costs associated with significant new regulations "shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations." It has been determined that the provisions announced in this document are actions that primarily

result in transfers, and thus are not a regulatory or deregulatory action for the purposes of Executive Order 13771.

**V. Waiver of Proposed Rulemaking and Delay of Effective Date**

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 553(b) of the Administrative Procedure Act (APA) and section 1871 of the Act. In addition, in accordance with section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act, we ordinarily provide a 30 day delay to a substantive rule's effective date. For substantive rules that constitute major rules, in accordance with 5 U.S.C. 801, we ordinarily provide a 60-day delay in the effective date.

None of the processes or effective date requirements apply, however, when the rule in question is interpretive, a general statement of policy, or a rule of agency organization, procedure or practice. They also do not apply when the statute establishes rules that are to be applied, leaving no discretion or gaps for an agency to fill in through rulemaking.

In addition, an agency may waive notice and comment rulemaking, as well as any delay in effective date, when the agency for good cause finds that notice and public comment on the rule as well the effective date delay are impracticable, unnecessary, or contrary to the public interest. In cases where an agency finds good cause, the agency must incorporate a statement of this finding and its reasons in the rule issued.

The policies being publicized in this document do not constitute agency rulemaking. Rather, the statute, as amended by the Consolidated Appropriations Act, 2018, has already required that the agency make these changes, and we are simply

notifying the public of the changes to the payment adjustment for low-volume hospitals for FYs 2011 through 2017 relating to the application of the mileage criterion for IHS and non-IHS hospitals. As this document merely informs the public of these changes, it is not a rule and does not require any notice and comment rulemaking. To the extent any of the policies articulated in this document constitute interpretations of the statute's requirements or procedures that will be used to implement the statute's directive, they are interpretive rules, general statements of policy, and rules of agency procedure or practice, which are not subject to notice and comment rulemaking or a delayed effective date.

However, to the extent that notice and comment rulemaking, a delay in effective date, or both would otherwise apply, we find good cause to waive such requirements. Specifically, we find it unnecessary to undertake notice and comment rulemaking in this instance as this document does not propose to make any substantive changes to the policies or methodologies already in effect as a matter of law, but simply applies payment adjustments under the Consolidated Appropriations Act, 2018 to these existing policies and methodologies. As the changes outlined in this document have already taken effect, it would also be impracticable to undertake notice and comment rulemaking. For these reasons, we also find that a waiver of any delay in effective date, if it were otherwise applicable, is necessary to comply with the requirements of the Consolidated Appropriations Act, 2018. Therefore, we find good cause to waive notice and comment procedures as well as any delay in effective date, if such procedures or delays are required at all.

CMS-1709-N

**Dated:** August 16, 2018

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**Seema Verma,**

Administrator,

Centers for Medicare & Medicaid Services.

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